Welcome to the Beginning of Your Healing Journey!

Name _____ Date _____

Address _____

_____

_____

Phone (C) _____ ☐ message ok?

(H) _____ ☐ message ok?

(W) _____ ☐ message ok? **Please circle preferred contact method.**

Email: _____

Date of Birth _____/_____/_____ If under 18, parent/guardian's Name _____

Age _____ Phone Number _____

Emergency Contact Information

Name _____ Relationship _____ Phone _____

How did you hear about us? _____

As a professional courteously, may we send a note to thank them for the referral? ☐ Yes ☐ N

Informed Consent

1. Following is the contract for services between Daryl Thorne, Ed.D, LCPC, (Clinician) and _____ (Client). This contract is dated _____, and will remain in effect until written changes are agreed to by both parties. **Initials** _____

2. Credentials:

   - Clinician is a Nationally Certified and Licensed Clinical Professional Counselor in the State of Maryland, holding the degrees of Doctor of Education in Counseling Psychology and Master's of Education in Guidance and Counseling. Clinician is committed to providing caring and professional mental health care to Client.

3. Client Rights and Important Information:

   - Client is entitled to receive information about methods of therapy, therapy techniques used, the duration of therapy (if it can be determined by Clinician), and fee structure.
   - Generally, the information provided by and to Client during therapy sessions is legally confidential, meaning that the Clinician cannot disclose confidential information without the Client's consent. Noted exceptions to this general rule are:
     - When a Client discloses intentions or a plan to harm him/herself or others;
     - Information concerning abuse of children or vulnerable adults; and
     - When a court order requires release of Client records.

     *For more detailed information, see the Notice of Privacy Practices. **Initials** _____

4. Fee Information*:

   - Following is the agreed upon fee structure for services:
     - 75 Minute Couples Intake/Assessment session: _____ $206
     - 60 Minute Individual Intake/Assessment session: _____ $166
     - 45-50 Minute Individual Therapy regular session: _____ $146
     - 45 Minutes of Reiki treatments: _____ $90
     - 90 Minute Couple Therapy regular session: _____ $186
     - Reiki as adjunctive to individual or couples sessions _____$50 (additional)

   - Yearly cost of living (COL) increases are effective each April 1st at the rate of 4% rounded to the nearest dollar. Current clients will be notified on the impending fee increase no less than 30 days prior to the increase. Clients securing services beginning on or after April 1st are bound by the most recent fee in accordance with the COL adjustment*.

   - **Full fee will be charged for any missed or canceled appointments with less than 24 hours notice**. Monday appointments must be canceled by Friday. Please refer to the above options available regarding emergencies, illnesses, or circumstance beyond your control.

- Lateness on the part of the Client does not alter the session fee or the ending time of the session. Lateness on the part of the Clinician will always be made up.

- In the event of inclement weather, please call the office to find out if office sessions are cancelled. Telephone sessions remain options. Fees for these sessions are to be paid via PayPal at least 1 hour prior to the start of the session. Credit cards are accepted via PayPal only.

- Fees may change in the future and Client will be notified in writing at least 30 days prior to any fee change.

- There will be a $25.00 fee for any returned checks. **Initials** _____

5. Emergencies and After Hours:

- Office phone is for voicemail only. Clinician does not offer after hour emergency services. If you have an emergency, please call 911 or go to your local emergency room.

6. Informed Consent to Treat Minors (under age 18):

- I/we consent that _____may be treated as a client by Daryl Thorne, Ed.D, LCPC.
- I/we understand information shared by the client in counseling sessions remain confidential except for the following: Expressed harm to self or others (e.g., suicidal or homicidal ideation), suspicion of abuse, neglect or evidence of the same. In the above situations, disclosure, consultation or referrals to appropriate professionals, agencies, or support systems will be made in the best interest for the client.

Initials _____

By signing below, I acknowledge that I agree with the above and that I have received copies of the Notice of Privacy Practices.

_____ _____
Client Signature Date

_____ _____
Client Signature (If under 18, signature of parent or guardian required) Date

_____ _____
Clinician Signature Date

Client Intake

What do you want to focus on in therapy? _____

_____

Are you feeling: ☐ Depressed ☐ Anxious ☐ Angry ☐ Suicidal ☐ Homicidal
☐ Frustrated ☐ Worried ☐ Hurt ☐ Afraid ☐ Confused

Counseling History:

Have you received any previous counseling or other therapeutic assistance? ☐ Yes ☐ No
Please explain (including when, for how long, was it helpful?)

_____

_____

Medical History:

Are you suffering from any Medical conditions at this time? If yes, please explain:

_____

_____

Medication, non-prescription drugs, & herbal supplements you are now using / and the amount?

_____

_____

Family History:

Are you? ☐Single ☐Committed Relationship ☐Married ☐Divorced/Separated ☐Other_____
Do you have any children? (names/ages) _____
Who is living in your home now: _____

Risk Assessment:

Are you aware of yourself/a child/family member having been abused (physically/sexually etc.)?
Please explain: _____

_____

Are you having or had in the past any thoughts of hurting yourself or others? Please explain:

_____

_____

Describe *your* use of alcohol and drugs and their use of *those living with you*: _____

_____

Have you or family members, in the past or at present, had problems/addiction with drugs, alcohol, food, sex, gambling, other? Please explain:_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. Please review it carefully.

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Daryl Thorne, Ed.D., LCPC safeguards the protected health information of people who receive services from her.

Protected health information includes descriptive information that can be used to identify a person and that relates to the physical or mental health or condition, the health care provided to the person, or payment for the health care. The protected health information includes information from the past, present, or future. The right to privacy continues after death.

You have the right to expect that only those individuals, organizations and/or agencies that have a need to know will be granted permission to use your protected health information, unless otherwise allowed by law or by your written authorization.

This notice will explain your rights more completely. These rights are the same as rights under 34B MRSA § 5605 et seq., Rights of Recipients of Mental Health Services, or Rights of Recipients of Mental Health Services who are Children in Need of Treatment.

1. Who I am
This notice describes the privacy practices of Daryl Thorne, Ed.D., LCPC, including all psychotherapy services.

2. My Privacy Obligations
I am required by law to keep your protected health information private, to tell you about these rules and to follow the rules.

3. Disclosing and Using Your Information with your consent
When you begin receiving services from me, I will ask that you (or your legally authorized representative) to sign a consent form, which will permit me to release information about you in order to provide services to you, in order to be paid by your insurance company for the services provided to you, and to conduct our regular business activities.

Your consent will permit me to share information with other parties who provide services to you when you give consent to do so. I will specifically ask your permission to share information related to psychotherapeutic treatment.

I will share information with
- Providers in the community who provide services to you,
- Your insurance company, so your services will be paid for

I will also share information to resolve any complaints or grievances that you may have.

You may request to have the use or disclosure of your protected health information restricted. I do not have to agree to the restriction you request. If I do agree, I must make a record of the restrictions and I must honor them.

If you wish to have information provided to other parties, you will be asked to sign an authorization. The authorization will allow me to provide information to others. I cannot provide information that was given to me by someone else. You may revoke this authorization at any time by providing a written dated notice.

4. Using Your Protected Health Information for Other Purposes
Generally, I may use your protected health information for other reasons only when I have a specific authorization signed by your or your legally authorized representative. I will use your protected health information when necessary to contact you about appointments and to provide you with information I think you may be interested in. You may provide me with another address or method to contact you and I will honor that request.

There are some times when I may be unable to obtain your consent or an authorization and I will still need to use your protected health information. I will use only what is absolutely necessary to accomplish the purpose. Examples of when I might use protected health information about you without consent or authorization include:

- If you need emergency treatment
- If you are incapacitated and I believe you would consent if you could
- If I find any of these situations, which I am legally required to report:
  - Cases of suspected abuse and neglect of children and incapacitated adults
  - If I believe you represent a threat to the safety of someone in the community or yourself.

There are also times when I am required to provide information about you. For example, I may be required to provide information about you in response to a court order (including to certain law enforcement officials).

5. Reviewing your Protected Health Information
You have the right to inspect and obtain a copy of protected health information maintained in my files. You will be expected to make an appointment for this and you will be charged fees for copying. You may also request that your records be sent to a mental health professional for their review. If you choose to do this, you will be charged fees for copying. Some protected health information in our files, particularly if it was provided to me by others, may not be reviewed or copied.

6. Amending your Protected Health Information
You have the right to amend your protected health information in my files for as long as that protected health information is maintained in our files. You may not amend material that was not created by me. You may add written material to your record to clarify information if you believe the information is false, inaccurate or incomplete. You may amend your records once annually at no cost. If you amend your records more frequently, you will be charged fees for copying.

7. Disclosures
You have the right to request an accounting of all disclosures of your protected health information that I may make if the disclosure was for something other than treatment, payment or my business needs. You have the right to request an accounting of any disclosures you authorized.

Information and Complaints

If you want more information about your Privacy Rights or our Privacy Practices, or are concerned that I have not followed these rules, you may contact the Maryland Department of Health and Mental Hygiene, Board of Professional Counselors and Therapists, Baltimore, MD. I will not retaliate against you if you file a complaint of any kind.

Duration of this notice

This notice goes into effect on July 1, 2004. I may change the terms of this notice at any time. If I do so, you may obtain any new notice by request.